TO: Michael Marshall, Secretary of Senate
Mark Brandsgard, Chief Clerk of the House

FROM: Jennifer Steenblock, Long Term Care Program Manager,
Iowa Department of Human Services, Iowa Medicaid Enterprise

SUBJECT: Direct Care Worker Compensation Advisory Committee Report

DATE: December 11, 2008

Enclosed please find copies of the report to the General Assembly relative to the Direct Care Worker Compensation Advisory Committee. This report is prepared pursuant to the directive contained in House File (HF) 2539, Section 70.

In accordance with this legislation, the Department of Human Services was directed to convene an advisory committee to complete an initial review of wages and other compensation paid to direct care workers, focusing on nonlicensed direct care workers employed in the nursing facility setting. Following the committee's deliberations, the committee is to submit a report of its finding and recommendations regarding improvement in direct care worker wages and other compensation paid to those employed in the nursing facility setting.

As the Department's designee to convene and facilitate the advisory committee, this report has been prepared on behalf of the Direct Care Worker Compensation Advisory Committee members. The Department's role in this advisory committee was to facilitate collection and presentation of information to members and provide staff support to the committee for creation of report based on committee findings.

This initial review was directed to non-licensed direct care workers employed in a nursing facility setting. Following this initial review and recommendations included in the attached report, legislation requires a subsequent advisory committee be convened to review the turnover rates, wages and other compensation paid to the entire spectrum of direct care workers. This next review is to include all settings in which direct care workers are employed.

The attached report includes the Direct Care Worker Compensation Advisory Committee recommendations from the initial review, with focus on direct care workers in the nursing facility setting.

Enclosure

cc: Office of Governor Culver
Legislative Service Agency
Eugene Gessow, Director, Iowa Department of Human Services
Jennifer Vermeer, Iowa Medicaid Director
Molly Kottmeyer, Legislative Liaison, Iowa Department of Human Services
Peter Matthes, Senate Minority Caucus
Kris Bell, Senate Majority Caucus
Brad Trow, House Minority Caucus
Zeke Furlong, House Majority Caucus

Direct Care Worker
Compensation Advisory Committee
Review and Recommendation Report

In accordance with
House File 2539, Section 70
2008 Session of the Iowa General Assembly

Prepared by:
Iowa Medicaid Enterprise, Bureau of Long Term Care
Contact: Jennifer Steenblock, 515-725-1299 or jsteenb@dhs.state.ia.us

Submitted to the Iowa Legislature by
Eugene I. Gessow, Director
Iowa Department of Human Services
December 11, 2008

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I. Executive Summary

The 2008 general assembly acknowledged in House File (HF) 2539, Section 70 that it recognizes direct care workers play a vital role and make a valuable contribution to Iowa's Health Care Reform efforts in providing care to Iowans with a variety of needs in both institutional and home and community based settings. The legislation identified that recruiting and retaining highly competent direct care workers is a challenge across all healthcare employment settings.

In accordance with this legislation, it is the intent of the general assembly to address the long-term care workforce shortage and turnover rates in order to improve the quality of healthcare delivered in the long-term care continuum by reviewing wages and other compensation paid to direct care workers in the state.

To do so, the Department of Human Services (DHS) was directed to convene an advisory committee to complete an initial review of and provide recommendations for improving wages and other compensation paid to direct care workers. The initial review is directed to non-licensed direct care workers in the nursing facility setting. Following the initial review, a subsequent advisory committee is to be convened with appropriate representatives of public and private organizations and consumers to review the wages and other compensation paid to and turnover rates of the entire spectrum of direct care workers in the various settings in which they are employed.

See *Appendix B* for the specific language of this legislation (HF 2539, Section 70).

As part of the advisory committee deliberations, members reviewed and discussed various reports and analysis relative to direct care worker wages and compensation. Following general discussions on reaction to the data and identification of issues related to direct care worker wages and compensation, the committee offers this report for legislative consideration.

II. What is the "Value" of the Care Provided to Iowa's Elderly and Disabled?

Direct care workers are the backbone of the formal long-term care system. In Iowa, these workers provide necessary care and support to thousands of elderly individuals as well as younger individuals with chronic diseases and disabilities. The acuity of the resident population in Iowa nursing facilities continues to increase; residents are more frail and have greater care needs. According to the national Alzheimer's Association in 2000 there were nearly 65,000 people living in Iowa with a diagnosis of Alzheimer's disease, with a projected increase of 6% by 2010 resulting in an estimated 69,000 people. [i] As the number of residents with Alzheimer's disease or dementia diagnosis increases, the demand will continue to grow for qualified and trained direct care workers.

Iowa has a fast-growing aging population, and this will result in increased need for direct care workers. Nursing facilities are competing with other businesses for employees who

seek adequate wages and benefits. According to PHI National, the demand for direct care workers in Iowa is at an all-time high, but growth in the labor supply is declining. Nursing aides, orderlies and attendants are among Iowa's top ten occupations with the largest job growth over the next decade, projecting to add over 25,000 new positions.[ii]

"Direct-care workers leave their jobs due to low pay, poor health care and other benefits, lack of initial and ongoing training, few advancement opportunities and the emotional and physical demands of the work." [iii] There are many potential ways to determine what the appropriate wage of the work done by direct care workers should be, although comparison is often made between the wages of direct care workers and those employed in the retail and fast food industries. Such a comparison is inappropriate-- direct care workers should not be considered an "entry-level" position considering the skill level needed, training and certification requirements.

The work of this committee, and others, comes down to a simple goal: to achieve changes in long-term care policy and practice that help to reduce high vacancy and turnover rates among direct care staff in nursing facilities and contribute to improved workforce quality.

To do that, appropriate wages, benefit and support are critical. The world of long term care and direct care workers can no longer be viewed through the lens of abstract public policy and line items in a lengthy budget document. Rather, it must be viewed through the lens of personal experience and real life impacts on our parents, spouses, siblings, children and others—including ourselves—that have dealt, or will deal, with the implications of lessened abilities due to the aging process or a disabling condition.

All whose lives have been touched by a direct care worker in a health or long term care setting know the critical importance of the work, the value of a helping and compassionate hand, the periodic need for a willing listener, and the inestimable value of having someone in the room who truly cares.

What is the value of the work of a typical certified nurse aide (CNA) that works in an Iowa nursing facility? It is the challenge of this committee to estimate the value and identify strategies to lessen the gap between what is and what should be. By comparison, the tasks, training and certification requirements for a CNA in a nursing facility compares with the work and training done by CNAs in Iowa's state-run long-term care facilities. The state job classification for these employees is resident treatment workers. The characteristics and needs of the residents served in these facilities are similar.

The value of a state employed CNA can be readily determined by looking at the hourly pay ranges of $13.82 to $20.20.[iv] At present, CNAs employed in Iowa nursing facilities (non-state operated) have a starting wage of approximately $9.24 per hour, and earn an average wage of approximately $11.52 per hour.[v]

An alternative way of looking at the economic value of professional caregivers can be found by looking at a different, but related category of people: the number and value of uncompensated, family caregivers. According to AARP's November 2008 report, Iowa

had an estimated 300,000 family caregivers in 2007 who provided care throughout the year, and an estimated total of 450,000 family caregivers who provided care at least at some point in 2007. The calculated estimate of the economic value of their unpaid contribution was $3.4 billion in Iowa.[vi] This is a way of quantifying something most people intuitively know: Proper care for our loved ones is personal and extremely important. Additionally, ensuring an adequate supply of qualified and adequately compensated professional caregivers is one way to relieve some of the pressures placed upon family caregivers.

As policymakers focus more attention on quality outcomes in long-term care, the need for a prepared, committed and sustainable long-term care workforce must become an increasing priority. It is the goal of this advisory committee that the highest appropriate level of wages and benefits possible are available to individuals who choose to be employed as direct care workers. The wages should be at a level that is family and life sustaining. Life sustaining wage levels, as defined by the Iowa Policy Project in 2008, equaled $13.92 per hour for a single parent with one child and $16.90 per hour for a single parent with two children. The compensation of direct care workers should be such that it encourages Iowans to enter and stay in a workforce that is valued and treated as professionals.

III. Introduction and Background

The Department of Human Services (DHS) convened an advisory committee to complete an initial review of and recommendations for improving wages and other compensation paid to direct care workers with a focus on non-licensed direct care workers in the nursing facility setting.

According to the legislation, the following organizations are to be represented on the committee:

Organization	Assigned Committee Member
Department of Human Services (Director or designee)	Jennifer Steenblock (facilitator)
Department of Public Health (Director or designee)	Michelle Holst
Department of Elder Affairs (Director or designee)	Terry Hornbuckle
Department of Inspections and Appeals (Director or designee)	Dean Lerner
Iowa Caregivers Association	John Hale
Iowa Health Care Association	Doug Johnson
Iowa Association of Homes and Services for the Aging	Kris Hansen
AARP Iowa Chapter	Anthony Carroll
Two members of the senate	Senator Becky Schmitz
Two members of the house of representatives	Representative Tyler Olson

The legislation requires the committee to consider options related but not limited to:

1. Shortening of the time delay between a nursing facility's submittal of cost reports and receipt of the reimbursement based upon these cost reports.
2. The targeting of appropriations to provide increases in direct care worker compensation.
3. Creation of a nursing facility provider tax.

In accordance with the legislation, DHS provided members with a detailed analysis of trends in wages and other compensation paid to direct care workers. Prior to the first meeting, each committee member received:

1. Information from the Bureau of Labor and Statistics relative to trends in wages for direct care workers.
2. Current average salary information for direct care workers employed in Iowa's Medicaid-certified nursing facilities based on submitted cost report data.
3. Trended salary information from Iowa Medicaid cost reports.
4. Information that describes wage and compensation experiences in Iowa.
5. Information describing wage and compensation experiences from other states.

Committee Workplan

The Direct Care Worker Compensation Advisory Committee met five times between September 10 and December 2, 2008. The committee agreed on the following strategy to guide the direction and focus of the committee:

1. Receive the "facts" (information and explanation) relative to direct care worker wages and other compensation.
2. Discuss observations regarding information provided (what do the facts tell us, or not tell us?)
3. Do we need more information? (If so, what is a reasonable timeframe to gather?)
4. Based on deliberations (discussion of the information and observations), do we conclude something should be changed?
5. Consider options for changes (discuss what could be changed, how it would look and what it may cost).
6. Formulate recommendations into report format.

Committee Timeline:

Following its deliberations, the committee is required to submit a report of its findings and recommendations regarding improvement in direct care worker wages and other compensation in the nursing facility setting to the Governor and the General Assembly no later than December 12, 2008.

Below are the meeting dates and timeline the committee agreed to follow in order to complete the report:

- September 10 – Receive "facts"; discuss observations; and determine if more information is needed.

- October 3 – Receive additional information (facts); discuss observations
- October 21 – Determine if changes are needed; discuss options
- November 7 – Final consideration of options (changes); formulate recommendations
- December 2 – Final review of recommendations; draft report
- December 12 – Report Due

Who Are "Direct Care Workers"?

Direct care workers, as defined by the Iowa Direct Care Worker Task Force, are individuals who provide "… services, care, supervision, and emotional support to people with chronic illnesses and disabilities. This definition does not include nurses, case managers, or social workers."[vii] Direct care workers may perform a variety of tasks. People familiar with direct care services generally categorize them into three broad categories: "environmental/chore, instrumental activities of daily living, and personal care."[viii]

According to the December 2007 Health and Long-Term Care Workforce Review and Recommendations report prepared by the Iowa Department of Public Health, the supply of direct care workers is impacted by many factors. The factors include the compensation offered for the occupation, educational requirements, benefits and working conditions.[ix] Direct Care workers are among the lowest paid of the health care workers and receive the most limited job-related benefits such as employer-paid health insurance.[x] "Nearly one in four wage and salary workers age 25 and older living in rural (nonmetro) America in 2005 were low-wage workers" as defined by living at 100 percent of the federal poverty level. Of these, one out of every 2 is a direct care worker."[xi]

Iowa's Better Jobs Better Care Coalition was interested in stabilizing the pool of quality direct care workers. According to the Coalition in a 2004 report, Direct Care Workers are[xii]:

- An estimated 55,000 Iowans who work on the front lines of nursing homes, assisted living centers, hospitals, hospices, in private residences and other settings throughout the state.
- "Hands-on" – helping clients and residents eat, dress, bathe, groom, toilet, take medications and exercise. They are there to listen, show interest and demonstrate concern and compassion. Those they care for often view them as "family".
- Among Iowa's oldest and poorest workers:
  - Certified Nurse Aides (CNAs) earn an average of $10.77 an hour.
  - One in four CNAs live in a household with income less than $18,000 per year.
  - 70% of CNAs live in a household with income less than $39,000 per year
  - They work in an industry with the highest number of workers age 65 and over.
  - 96% are women
  - 77% live in a rural area.
  - 25% of CNAs have NO health care coverage.
  - 12% of CNAs rely on public assistance for health care coverage.

Impact of Direct Care Worker Turnover

Iowans are living longer, and those 85 years of age and older are the fastest growing sector of our population. As the baby boomers are reaching retirement age, the demand for services are growing. According to a Better Jobs Better Care (BJBC) Practice and Policy report issued in October 2004, "The most commonly used, conservative rule-of-thumb for estimating the per worker cost of turnover in the overall U.S. economy puts the comprehensive cost of replacing a lost employee at 25% of his or her annual compensation amount."[xiii]

Employee Turnover "Facts"[xiv]

- Turnover of CNAs has been estimated at 60% and above annually.
- Turnover occurs due to low pay, poor benefits, lack of high quality initial and ongoing education, few advancement opportunities within the direct care field and the emotional and physical demands of the work.
- Turnover costs dollars. Estimates are that Iowa consumers and taxpayers spend $44.61 million dollars annually to pay for the costs of recruiting and training new CNA's in nursing facilities.
- Turnover results in less quality of care. When the continuity of care is disrupted—when a person with knowledge of and a relationship with a client or resident is replaced by someone new—quality and client satisfaction declines.

Numerous efforts have been made to identify the elements that encourage people to enter or leave a profession. One such effort has been made by PHI, a New York City-based organization known nationally for its research and policy advocacy regarding the direct care workforce. According to PHI[xv], there are nine elements of a quality job:

1) Family Sustaining **Wages**
2) Affordable **health insurance** and other family-supportive benefits
3) **Full-time hours**, if desired, stable work schedules, balanced workloads, and no mandatory overtime
4) **Excellent training** that helps each worker develop and hone all skills-both technical and relational-necessary to support long-term care consumers
5) **Participation in decision making**, acknowledging the expertise that direct-care workers contribute, not only to workplace organization and care planning, but also to public policy discussions that impact their work
6) **Career advancement** opportunities
7) **Linkages** to both organizational and community services, as well as to public benefits, in order to resolve barriers to work
8) **Supervisors** who set clear expectations and require accountability, and at the same time encourage, support and guide each direct-care worker
9) **Owners and managers** willing to lead a participative, ongoing "quality improvement" management system—strengthening the

core caregiving relationship between the long-term care consumer and the direct-care worker

It is important to note that this report addresses PHI's elements 1 (wages) and 2 (health insurance). Also, PHI's element 2 (health insurance) is being addressed by the pilot project designated in House File (HF) 2539, Section 72, which is to design a voluntary employer sponsored health care coverage demonstration project for direct care workers. Additionally, PHI's element 4 (excellent training) is being addressed by the Direct Care Worker Advisory Council, also established by HF 2539 in Section 69.

IV. Summary of Research

The primary task of this advisory committee is to evaluate the wages and benefits of direct care workers, identify if there are problems that exist in direct care worker wages and benefits, and determine suggested solutions that could be formulated into recommendations to the legislature. Committee members were provided with a wide variety of information and data. All information provided was discussed, reviewed and clarified. It is this information that members used in their deliberations to identify problems and formulate recommendations for consideration.

See *Appendix B* for listing of information and data sources reviewed by advisory committee members.

V. Observations

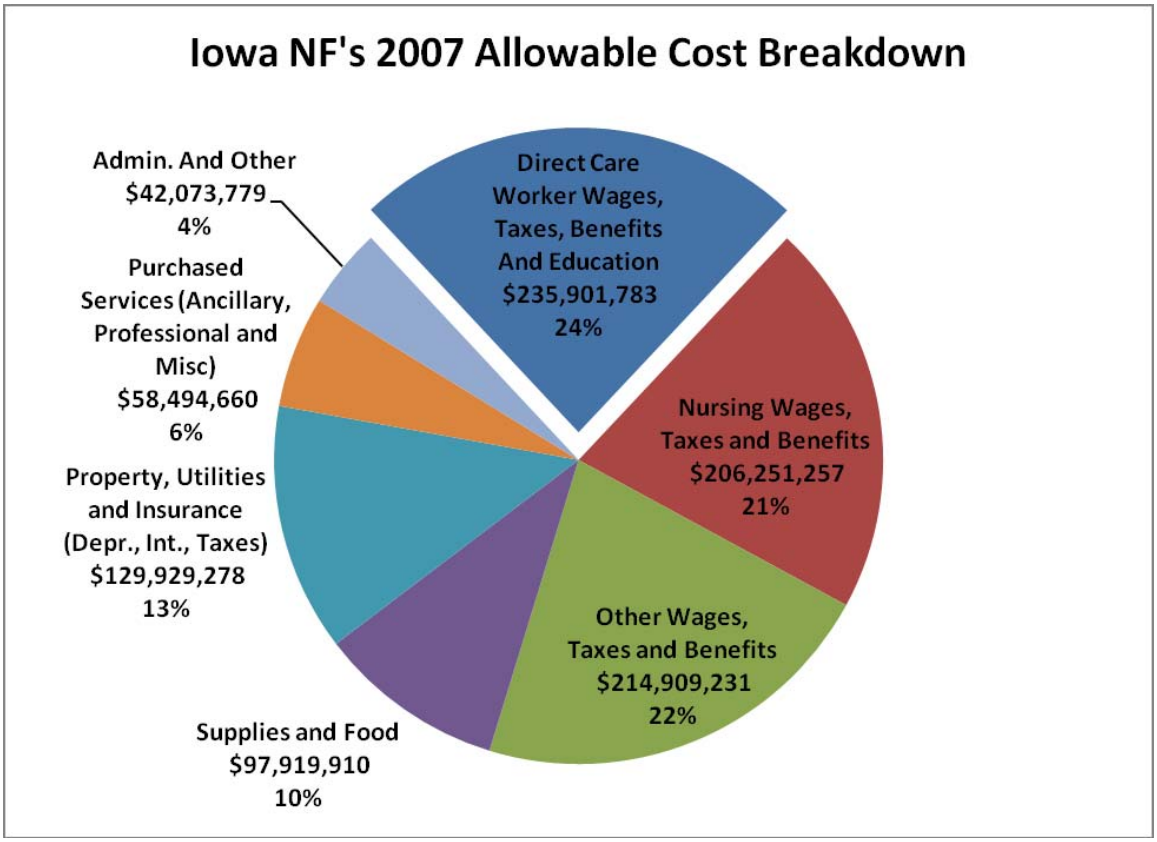
During the review and discussion, the advisory committee reviewed analysis of trends in wages and other compensation, as well as information from the Medicaid cost reports. Following are the observations made by the advisory committee.

There are four primary components that comprise funding (revenue) for care in our nursing homes: [xvi]

Chart 1: 2007 Long Term Care Revenue

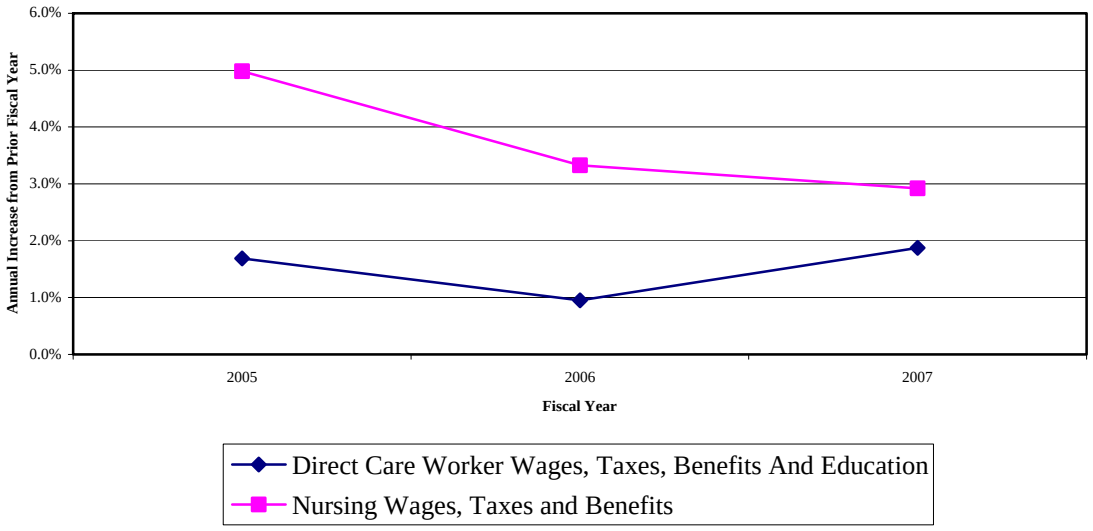
Funding Source	Percentage	Amount
Private Pay	45 %	$ 628,102,636
Medicaid Client Participation	9 %	$ 124,159,781
Medicaid	32 %	$ 448,111,515
Medicare	14 %	$ 195,409,709
TOTALS	100 %	$ 1,395,783,641

Chart 2: Nursing Facility Allowable Cost – Summary of Cost Report Compilation Data



The cost of direct care workers is the single largest component of costs of a nursing facility. The tables included in Appendix E prepared by the Iowa Health Care Association demonstrate summarized cost report data from recent years. Approximately 24% of the cost of care in Iowa Nursing Facilities was for Direct Care worker wages and other costs of employment (see chart 2 above). In 2007 this totaled nearly $236 million dollars. Other data included in Appendix E serves to demonstrate the array of costs as well as percentage of increase in recent years.

Chart 3: Comparison of Nursing and Direct Care Worker Compensation



The Direct Care Worker Compensation Advisory Committee recognizes that increases in direct care workers compensation and benefits has not grown at the same rate as other cost groupings and was not keeping with inflation. The advisory committee discussed various factors that may be influencing cost changes.

See *Appendix E* for the detailed information to Charts 2 and 3.

General Reaction and Discussion to Data Provided

During committee discussions, identified issues fall under the following areas of common themes:

1) Value of direct care workforce. The advisory committee recognizes the value that the direct care workforce brings to the quality care provided to Iowans. Any strategies implemented to increase direct care worker compensation must work hand-in-hand with the other direct care workforce initiatives currently being discussed, including those specified in House File 2539 (Direct Care Worker Education and Certification Advisory Council, Medicaid Cost Report Turnover Report, and Demonstration Project for Voluntary Employer Sponsored Health Care Coverage for Direct Care Workers).

   Long-term care is one of the fastest-growing fields in the economy and, as such, is a powerful job engine for direct care occupations as well as an important entry point into licensed health-related occupations.

The unfortunate reality is that society, to date, has been content to view direct care work—and direct care workers—as both invisible and insignificant. Direct care work is often viewed as consisting of dead-end, low-wage jobs that anyone can do rather than a profession that requires special talent and skills.

This is an outdated perspective. Direct care work is difficult, demanding and significant work; work to be respected and valued. A high quality direct care worker—one who has a gift of displaying the right combination of competence, compassion and commitment to the welfare of others—is indeed "priceless" to the individual and family being served. Additionally, turnover that runs over 60% a year creates an ineffective use of limited tax dollars and impacts the continuity of care.

2) Complex reimbursement system, transparency and verification. Direct care worker compensation is reported on the cost report along with other worker classifications. If increased reimbursement is targeted specifically to non-licensed direct care workers, need to also ensure some type of provider reporting in order to monitor that the increased reimbursement was spent on direct care worker compensation.

Under the case-mix system:

- Each nursing facility is reimbursed based upon the resources needed to provide care for residents given the residents' average acuities. (Resident acuities indicate levels of physical and cognitive functioning, as assessed through standardized federal health indicators.)

- To determine acuity, the Iowa Medicaid utilizes a federal assessment form, completed by the nursing facility, for each resident in the facility. To determine patient care service expenditures, each facility submits an annual cost report. Each facility's average aggregate resident care needs (i.e., the amount of nursing services needed to care for residents) and patient care costs then will be compared to statewide averages.

- The Iowa Medicaid payment rate is established for each nursing home based upon 120% of median for direct care costs and 110% of median for non-direct care costs given the residents' average acuities.

Policy makers should consider requiring a more transparent system detailing all revenue and expenditures. Such a system with its

clearly delineated data would facilitate better decision-making about priorities. In particular, if policymakers choose to increase salaries and benefits of direct care workers, a transparent and detailed system should be in place to measure whether the intended results are achieved.

3) Sustainable Funding: There are significant fiscal challenges in implementing strategies to increase direct care worker wages and benefits. Any efforts to increase the compensation must include a commitment for reliable and sustainable funding for providers of long-term care. Consideration must also be given to the potential impact of cost-shifting to the private pay residents when increasing direct care worker wages, if state and federal funding are not sustained.

VI. Conclusion

Direct care workers employed in non-state owned facilities are paid approximately 2/3 less, or 67% of their state-employed counterparts. Investing in direct care workers not only keeps these workers satisfied and on the job, but also goes to the heart of long-term care – the residents. Long-term care providers in Iowa need to make adequate compensation of the workforce a priority and think of it as a "workforce investment".

Bridging the Wage Gap
The wage goals established by the Direct Care Worker Compensation Advisory Committee are:

- A starting CNA wage of no less than 85% of the wage paid to a state employed CNA.
- An average wage no less than 85% of the average wage paid to a state employed CNA.

Is it realistic to expect the wage gap (the gap between the State of Iowa CNA and the private sector CNA) to be closed overnight? NO.

Should we expect the gap to be recognized and serious work begun to close it? IF WE TRULY VALUE THIS WORKFORCE AND THOSE THEY ASSIST, THE ANSWER IS YES.

VII. Recommendations

The recommendations found in this report include strategies to improve wages and benefits paid to direct care workers employed in Iowa's nursing facilities. In time, implementation of these strategies can help to "bridge" the wage gap for direct care workers.

After careful review of the facts presented on direct care worker compensation and committee member discussion of the issues identified regarding compensation for direct care workers, the following recommendations are presented for legislative consideration:

1. **Fully Fund the Current Modified Price-Based Case Mix Reimbursement System:**
   The Iowa Senior Living Program Act was enacted in 2001 by the legislature and governor and included legislation that established a "case-mix reimbursement" method to pay Iowa's nursing facilities as they provide care and treatment of older adults covered by the Medicaid program. (See page 12 for further description of the case mix reimbursement).

   Iowa's case mix reimbursement is a thoughtfully developed payment system intended to provide funding to nursing facilities and "reward" those facilities that put money towards direct care costs. This complex formula has never been fully funded as it was designed**.** During the rebases effective 7/1/03, 7/1/05 and 7/1/07, estimated expenditures were projected to exceed the appropriation cap. During each of the rebasing periods, the inflation factor was reduced to result in rates there were within the cap.

   With full funding of the case mix reimbursement system, one benefit could be a reduced cost of turnover. It is expected nursing facility providers would have funds available for direct care worker training, and increases in wages and benefits. In turn, providers could see a reduction in the turnover of staff, which is very costly. Ultimately, if costs related to turnover were decreased, there would be additional funds available to continue to improve the wages and benefits of the direct care workers employed by the nursing facilities.

   The Direct Care Worker Compensation Advisory Committee recommends providing appropriate funds necessary to meet the State of Iowa's obligation to Medicaid-eligible seniors receiving long-term care in case-mix funded nursing facilities and the direct care workers that provide the care.

2. **Modify Current Reimbursement Methodology to Include an Inflation Update in Non-Rebase Year:**
   The reimbursement system is a complex, prospective payment system. Currently, there is a bi-annual rate payment rate adjustment using a national standard. Every other year, rates are "rebased" using more recent cost report information. The payment rates are not adjusted during a non-rebasing year. In other words, the rates are set every other year using actual cost information (re-based). Because inflation is not included in a non-rebase year, the actual costs of the facility may not be recognized in the Medicaid payment rate during a non-rebase year. For example, payment rates established during a base year (effective 7/1/07) were based on calendar year 2006 costs with an inflation factor applied. The 7/1/07 rates are effective for a two-year period with a quarterly acuity adjustment (i.e. until the next rebase year 7/1/09).

   The Direct Care Worker Compensation Advisory Committee recommends the legislature provide nursing facilities with the Federal/Skilled Nursing Facility (SNF) market basket rate in the non-rebasing years. If this Federal/SNF market basket rate increase did not occur, direct care workers would see an increase in the rebasing year, but a potential wage freeze in the non-rebasing year as the nursing facilities are being paid on two-year-old costs.

   See *Appendix C* for further information demonstrating the importance of rebasing and inflation.

3. **Modify Calculation of Direct Care Median Component:**
   The advisory committee reviewed a significant amount of data demonstrating historical costs of providers, with emphasis on those costs that make up the Direct Care component of each providers Medicaid payment rate. It was noted that the current formula applying limits to provider payments caps the amount of the Direct Care Component at 120% of the median (after case-mix adjustments). The advisory committee learned that approximately 16% or 68 providers have current costs that exceed the Direct Care component limit, meaning that not all of their Direct Care costs were covered. There was discussion as to why there is any limit on the Direct Care component. If the limit were increased, would there be enough incentive for providers to increase direct care worker spending?

   For example, if the limit were increased to 125% of the median, approximately 1/3 of those 68 providers would receive full cost coverage. The remaining 40 or more facilities would still be under funded. The cost to increase the limit to 125% of the median would be approximately $1.6M total funding, or $600,000 in state dollars. This would increase reimbursement to the system in total and specifically to those providers

that have higher Direct Care costs. The estimated costs to remove the limit would be more than $6.8M in total, and would put no cost containment on that portion of the rate formula. The group also recognized that higher cost facilities might have regulatory issues or need improvements in overall efficiency. It would be most important to recognize increases in the Direct Care Component Limit, and the increases would need to be focused to the direct care workers.

4. **Modify Information Reported by Nursing Facilities on the Medicaid Cost Report:**
The advisory committee reviewed historical nursing facility cost report data demonstrating costs of employment for direct care workers. The data was obtained from two of the schedules included in the Medicaid Cost Report – Schedule's C and H. The group learned while total employment costs are reported for all the staff in the direct care category (payroll, taxes, benefits, workers compensation, etc.), there is not a specific breakdown by each of the primary job classifications. Discussion of this topic indicated that many providers might have this level of detail in their internal reporting systems; however, it is not required in the cost report submission. Additionally, the advisory committee came to the understanding that the specific line, Certified Nurse Aide, is something of a "catch-all" for all aide staff. The advisory committee believes that modifying the cost report form to demonstrate a greater level of detail concerning the costs of employment would significantly improve the transparency of the reporting system and would lead to a higher level of accuracy for future analysis or studies.

   The advisory committee discussed the burden that expanded reporting may place on providers. The group understands that with over 425 nursing facilities there are many different systems and that not all providers could make these changes immediately. Additionally, changes to the cost report form, instructions, Iowa Administrative Code and the Medicaid State Plan would require several months for completions and to receive federal approval from the Centers for Medicare and Medicaid Services (CMS). The recommendation to modify the cost report should include provider and other input to adequately address:
   - The specific data to be included
   - The modifications to the reporting form
   - The timeline for implementation of the cost report changes.
   - Require these changes at government-operated facilities to help determine the correlation of increased compensation and the level of costs of turnover

   Other cost report changes should also be considered to enhance the transparency discussed in this report.

The advisory committee discussed other options, but the time schedule for deliberation did not allow for additional research. Those options suggested for further research includes:

- Legislation that would create a direct wage pass-through, in the form of an appropriation to facilities that would be required to be used solely for increasing the wages of CNAs. Such an approach has been utilized in other states. For example, in 2007, Louisiana approved a $2.00 per hour wage pass through to increase the wages for direct care workers in long term care settings.

  Additional research in the various state approaches, and making a determination of the extent to which they were successful, would provide valuable information to policy makers.

- Legislation that would create either an expanded earned income tax credit or establish a new earned income tax credit targeted to low-paid yet high-value occupations such as direct care workers and childcare workers.

  Due to current budgetary environment, the advisory committee recognizes the wage goals established may not be possible to bridge the wage gap as soon as desired. Therefore, the possibility of increasing the amount of money received by a direct care worker by utilizing the tax code rather than the wage system was discussed but not fully deliberated. If an earned income tax credit for direct care workers existed, it would serve as an indirect way of increasing the standard of living for those who do this critically important work. It is important to note that this idea was discussed as a <u>supplement</u> to desired wage increase rather than an <u>alternative</u> to wage increases.

VIII. Options for Funding the Recommendations

The Direct Care Worker Compensation Advisory Committee was tasked with creating recommendations regarding wages and other compensation paid to direct care workers in nursing facilities. Part of the task was to consider options in targeting appropriations to provide increases to direct care workers.

As noted above, the Direct Care Worker Compensation Advisory Committee believes that direct care workers are the backbone of the formal long-term care system. Long-term care costs are largely paid by Medicaid and Medicare and significantly affect provider wages, benefits, certification and training requirements.

Direct care workers deserve fair compensation. The recommendations included in this report will help long-term care providers create an investment in the direct care workers. An investment in workers is an investment in quality.

Following are options for potential funding sources to make this investment:

1. General Fund: Policymakers could fund the recommendations from the General Fund and make an investment in the direct care workers, increase the supply of the direct care workers, promote greater workforce stability through increased compensation and reduce costs associated with high staff turnover.

2. State Fines: Under Iowa Code section 135C.36, the Iowa Department of Inspections and Appeals (DIA) has the authority to issue a fine for violation of state regulations. This money is deposited into the general fund. Policymakers could use a portion of this money to bolster nursing facility quality by investing in a stable workforce.

3. Accountability Measures: The 2001 Iowa Acts (HF 740) created intent by the General Assembly to initiate a system to measure a variety of elements to determine a nursing facility's capacity to provide quality of life and appropriate access to Medicaid in a cost-effective manner. During the 2008 legislative session, Senate File 2425, section 33 made changes to the Accountability Measures including the establishment of a workgroup that is to develop recommendations to redesign the accountability measure program. The Direct Care Worker Compensation Advisory Committee recommends that consideration be given to using some of these funds to increase the compensation to direct care workers.

4. Provider Tax: In accordance with the legislation that created the Direct Care Worker Advisory Committee, the group recognizes the importance of utilizing additional federal funds to offset the continued growth in overall Medicaid costs. More specifically, portions of increased funding from this source can be directed to wages and other costs of employment for employees in long-term care. This method of drawing down additional federal funding is used by 31 other states.

   In 2003, House File 619 gave the Department of Human Services (DHS) authorization to assess nursing facilities a quality assurance assessment (provider tax). The DHS submitted a state plan amendment (SPA) to the Secretary of the US Department of Health and Human Services, Centers for Medicaid and Medicaid, to implement the provider tax. In 2005, CMS and the federal government were no longer allowing intergovernmental transfers. In Iowa, the intergovernmental transfer was the mechanism used to fund the Senior Living Trust. Iowa agreed to end the intergovernmental transfers, as a condition of approval for an 1115 Demonstration Waiver, which allowed the state to implement the IowaCare Initiative. As a special term and condition of the 1115 IowaCare Demonstration, DHS agreed to not implement a nursing facility provider tax and was required to withdraw the pending SPA. As a result, the state was not able to implement the nursing facility quality assurance assessment (provider tax) created in HF 619. Advocates for the concept of a provider tax

believe that Iowa's recent economic challenges imposed by natural disasters and the economy may be cause for this IowaCare agreement to be renegotiated. The IowaCare Demonstration Waiver is scheduled for renewal effective July 1, 2010.

The Direct Care Worker Compensation Advisory Committee believes that effectively utilizing these additional resources could provide gains in wage and benefit planning and assuring the workforce of compensation growth to keep pace with statewide economic changes.

5. Expanded Medicaid Appropriations: At the time this report was in final drafting, conversations were occurring at the federal level to increase the amount of Medicaid dollars flowing to the states as part of a broadened economic stimulus package. The advisory committee recommends that if additional federal Medicaid funds are made available, and if the funds could be used for the purpose of increasing direct care wages or other forms of compensation, that consideration be given to do so.

IX. Appendices

Appendix A: House File 2539, Section 70
Appendix B: Information and Data Resources
Appendix C: Chart Demonstrating Rebasing and Inflation
Appendix D: Illustration of Average Per Diem and State Costs
Appendix E: Nursing Facility Allowable Cost – Summary from Cost Report Compilation Data

Appendix A: House File 2539, Section 70

House File 2539 - Enrolled

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HOUSE FILE 2539

66 23 Sec. 70. DIRECT CARE WORKER COMPENSATION ADVISORY
66 24 COMMITTEE == REVIEWS.
66 25 1. a. The general assembly recognizes that direct care
66 26 workers play a vital role and make a valuable contribution in
66 27 providing care to Iowans with a variety of needs in both
66 28 institutional and home and community=based settings.
66 29 Recruiting and retaining qualified, highly competent direct
66 30 care workers is a challenge across all employment settings.
66 31 High rates of employee vacancies and staff turnover threaten
66 32 the ability of providers to achieve the core mission of
66 33 providing safe and high quality support to Iowans.
66 34 b. It is the intent of the general assembly to address the
66 35 long=term care workforce shortage and turnover rates in order
67 1 to improve the quality of health care delivered in the
67 2 long=term care continuum by reviewing wages and other
67 3 compensation paid to direct care workers in the state.
67 4 c. It is the intent of the general assembly that the
67 5 initial review of and recommendations for improving wages and
67 6 other compensation paid to direct care workers focus on
67 7 nonlicensed direct care workers in the nursing facility
67 8 setting. However, following the initial review of wages and
67 9 other compensation paid to direct care workers in the nursing
67 10 facility setting, the department of human services shall
67 11 convene subsequent advisory committees with appropriate
67 12 representatives of public and private organizations and
67 13 consumers to review the wages and other compensation paid to
67 14 and turnover rates of the entire spectrum of direct care
67 15 workers in the various settings in which they are employed as
67 16 a means of demonstrating the general assembly's commitment to
67 17 ensuring a stable and quality direct care workforce in this
67 18 state.
67 19 2. The department of human services shall convene an
67 20 initial direct care worker compensation advisory committee to
67 21 develop recommendations for consideration by the general
67 22 assembly during the 2009 legislative session regarding wages
67 23 and other compensation paid to direct care workers in nursing
67 24 facilities. The committee shall consist of the following
67 25 members, selected by their respective organizations:
67 26 a. The director of human services, or the director's
67 27 designee.
67 28 b. The director of public health, or the director's
67 29 designee.
67 30 c. The director of the department of elder affairs, or the
67 31 director's designee.
67 32 d. The director of the department of inspections and

33 appeals, or the director's designee.
34 e. A representative of the Iowa caregivers association.
35 f. A representative of the Iowa health care association.
1 g. A representative of the Iowa association of homes and
2 services for the aging.
3 h. A representative of the AARP Iowa chapter.
4 3. The advisory committee shall also include two members
5 of the senate and two members of the house of representatives,
6 with not more than one member from each chamber being from the
7 same political party. The legislative members shall serve in
8 an ex officio, nonvoting capacity. The two senators shall be
9 appointed respectively by the majority leader of the senate
10 and the minority leader of the senate, and the two
11 representatives shall be appointed respectively by the speaker
12 of the house of representatives and the minority leader of the
13 house of representatives.
14 4. Public members of the committee shall receive actual
15 expenses incurred while serving in their official capacity and
16 may also be eligible to receive compensation as provided in
17 section 7E.6. Legislative members of the committee are
18 eligible for per diem and reimbursement of actual expenses as
19 provided in section 2.10.
20 5. The department of human services shall provide
21 administrative support to the committee and the director of
22 human services or the director's designee shall serve as
23 chairperson of the committee.
24 6. The department shall convene the committee no later
25 than July 1, 2008. Prior to the initial meeting, the
26 department of human services shall provide all members of the
27 committee with a detailed analysis of trends in wages and
28 other compensation paid to direct care workers.
29 7. The committee shall consider options related but not
30 limited to all of the following:
31 a. The shortening of the time delay between a nursing
32 facility's submittal of cost reports and receipt of the
33 reimbursement based upon these cost reports.
34 b. The targeting of appropriations to provide increases in
35 direct care worker compensation.
1 c. Creation of a nursing facility provider tax.
2 8. Any option considered by the committee shall be
3 consistent with federal law and regulations.
4 9. Following its deliberations, the committee shall submit
5 a report of its findings and recommendations regarding
6 improvement in direct care worker wages and other compensation
7 in the nursing facility setting to the governor and the
8 general assembly no later than December 12, 2008.
9 10. For the purposes of the initial review, "direct care
10 worker" means nonlicensed nursing facility staff who provide
11 hands=on care including but not limited to certified nurse
12 aides and medication aides.

Appendix B: Information and Data Resources

To better understand any issues related to the benefits and wages of direct care workers, advisory committee members reviewed and discussed a variety of information. Below is a summary of the data and information used by committee members in their deliberations to identify problems and formulate recommendations for consideration:

1. Medicaid-Certified Nursing Facility Cost Report Information:
    a) Historical salary information
    b) Information from Compilation Reports
    c) Summary of information currently captured on the Medicaid cost report
    d) Analysis of percentages between direct and non-direct care components in the rates and per diems using payment information from 7/1/08.
    e) Report of the number of facilities currently at the rate component caps.

2. Information on nursing facility rate setting for Medicaid
    a) Rate sheets to illustrate how rates are calculated
    b) Further information and explanation of medians for direct care and non-direct care.

3. Information provided by the Iowa Health Care Association (IHCA):
    a) American Heath Care Association's (AHCA) 2008 U.S. Long Term Care Workforce at a Glance
    b) IHCA and Iowa Center for Assisted Living (ICAL) Health Insurance Survey Results, January 2008
    c) IHCA 2007 Nursing Home Cost Analysis

4. United States (U.S.) Bureau of Labor Statistics (BLS), U.S. Department of Labor, 2007 Occupational Employment Statistics

5. Iowa Workforce Development 2007 Iowa Wage Survey

6. National Center for Health Statistics' 2004 National Nursing Assistant Survey

7. Better Jobs, Better Care 2004 CNA Wage and Benefit Survey Report

8. PowerPoint presentation made to the Iowa Direct Care Advisory Council in August 2008 by Dorie Seavey, Director of Policy Research, PHI National

9. State Chart Book on Wages for Personal and Home Care Aides from 1999-2006, compiled by PHI National

10. U.S. Department of Health and Human Services report on State Wage Pass-Through Legislation

11. Iowa's Health and Long-Term Care Workforce Review and Recommendations Report, December 2007

12. Iowa's Direct Care Worker Task Force Recommendations for Establishing a Credentialing System for Iowa's Direct Care Workforce, May 2008

13. Iowa's Direct Care Worker Taskforce Report and Recommendations, December 2006

14. Central States Salary Survey (2007) for positions similar to CAN

15. Information on CBSA and Metropolitan Statistical Area, including definitions and explanation.

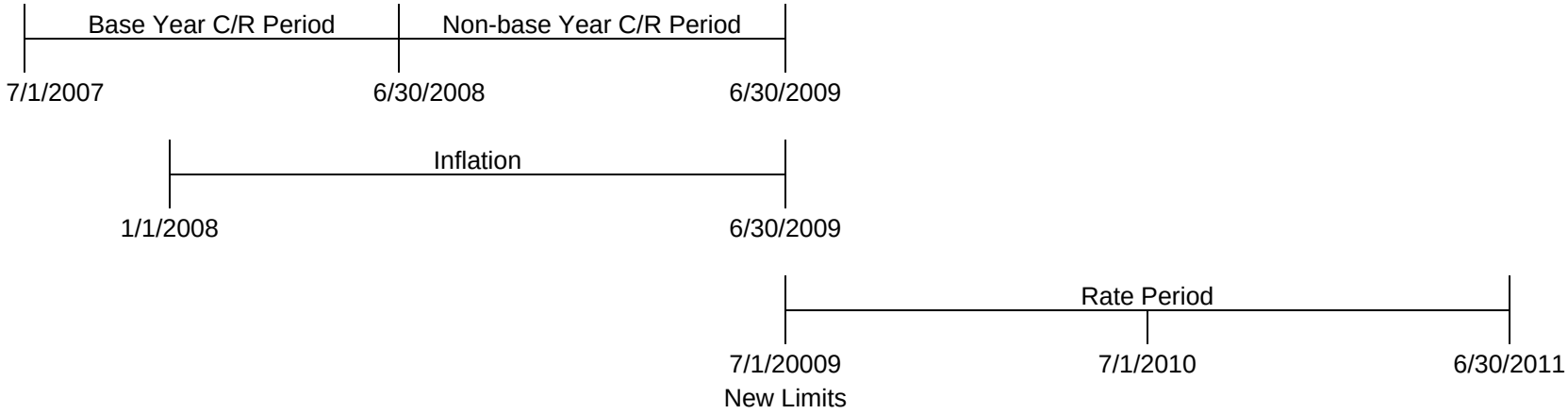
16. Information on provider taxes, including summaries of:
    a) Tax plans in place from the various states that have implemented provider taxes
    b) The concept of a provider tax
    c) The structure of a provider tax

17. Generation Iowa Commission Report, January 2008

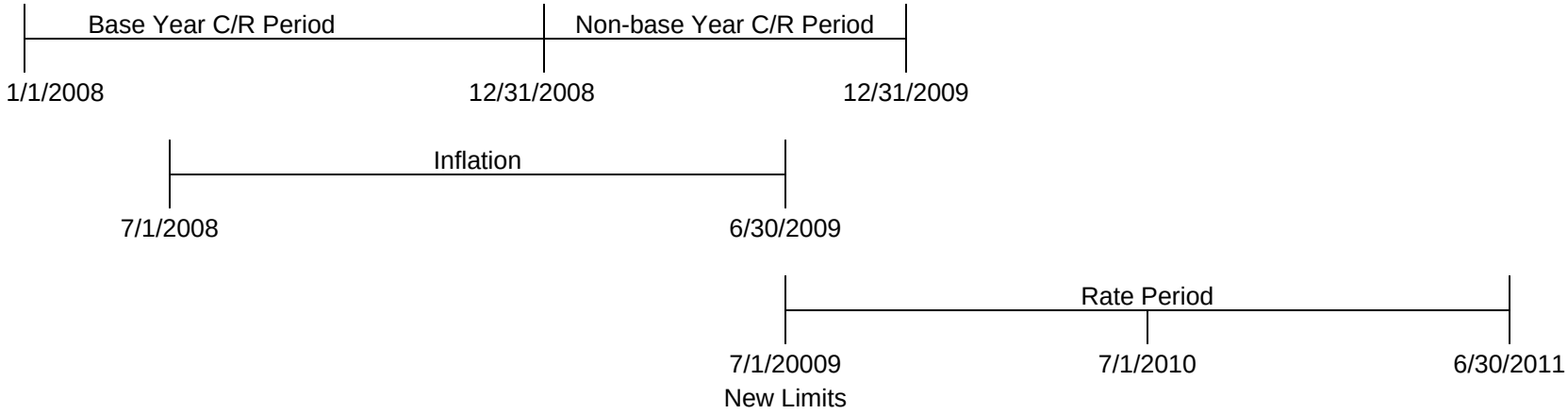
18. Information on the pay scale for resident treatment worker (RTW), a classification for State of Iowa employees, similar to that of a direct care worker employed in Iowa nursing facilities

Appendix C: Chart Demonstrating Rebasing and Inflation

Example 1: Cost report period ending June 30, 2008



Example 2: Cost report period ending December 31, 2008



Appendix D: Illustration of Average Per Diem and State Costs

	Average of 7/1/07, 10/1/07, 1/1/08 & 4/1/08 Actual Rates - After Appeals	
	Hospital-Based	Freestanding
Case Mix System		
Average October 1, 2007 Medicaid Rate	$ 463.53	$ 120.06
Less: Client Participation	7.39	25.54
Amount Subject to Match	$ 456.14	$ 94.52
State Match Rate	37.60%	37.60%
State Share Per Day	$ 171.51	$ 35.54
State Share Per Hour		$ 1.48

Appendix E: Nursing Facility Allowable Cost – Summary from Cost Report Compilation Data

NF Allowable Cost - Summary from Compilation Data	2004	2005	2006	2007
Number of Facilities Included	428	428	424	422
Average Occupancy	83.51%	82.77%	83.05%	82.27%
Medicaid Utilization	50.97%	50.86%	50.60%	50.17%
Cost Category				
Direct Care Worker Wages, Taxes, Benefits And Education	$ 225,561,316	$ 229,375,888	$ 231,555,784	$ 235,901,783
Nursing Wages, Taxes and Benefits	$ 184,744,407	$ 193,941,861	$ 200,394,633	$ 206,251,257
Other Wages, Taxes and Benefits	$ 204,356,109	$ 207,593,448	$ 209,428,171	$ 214,909,231
Supplies and Food	$ 88,742,323	$ 88,830,225	$ 92,428,763	$ 97,919,910
Property, Utilities and Insurance (Depr., Int., Taxes)	$ 121,054,731	$ 127,585,464	$ 128,167,884	$ 129,929,278
Purchased Services (Ancillary, Professional and Misc)	$ 45,732,258	$ 47,906,251	$ 49,526,412	$ 58,494,660
Admin. And Other	$ 38,780,660	$ 40,515,627	$ 41,053,775	$ 42,073,779
Total	$ 908,971,803	$ 935,748,765	$ 952,555,423	$ 985,479,898

Annual % Increase in Cost	2005	2006	2007
Direct Care Worker Wages, Taxes, Benefits And Education	1.7%	1.0%	1.9%
Nursing Wages, Taxes and Benefits	5.0%	3.3%	2.9%
Other Wages, Taxes and Benefits	1.6%	0.9%	2.6%
Supplies and Food	0.1%	4.1%	5.9%
Property, Utilities and Insurance (Depr., Int., Taxes)	5.4%	0.5%	1.4%
Purchased Services (Ancillary, Professional and Misc)	4.8%	3.4%	18.1%
Admin. And Other	4.5%	1.3%	2.5%
Total	2.9%	1.8%	3.5%
Annual % Of Total			
Direct Care Worker Wages, Taxes, Benefits And Education	24.5%	24.3%	23.9%
Nursing Wages, Taxes and Benefits	20.7%	21.0%	20.9%
Other Wages, Taxes and Benefits	22.2%	22.0%	21.8%
Supplies and Food	9.5%	9.7%	9.9%
Property, Utilities and Insurance (Depr., Int., Taxes)	13.6%	13.5%	13.2%
Purchased Services (Ancillary, Professional and Misc)	5.1%	5.2%	5.9%
Admin. And Other	4.3%	4.3%	4.3%
Total	100.0%	100.0%	100.0%

Source: Iowa Health Care Association

[i] Alzheimer's Association. *Alzheimer's Disease Facts and Figures 2007* (Washington, D.C.: 2007), accessible at www.alz.org ; search "2007 facts and figures."

[ii] PowerPoint presentation made to the Iowa Direct Care Advisory Council in August 2008 by Dorie Seavey, Director of Policy Research, PHI National

[iii] Iowa Caregivers Association. Health Care for Health Care Workers. *Providing Health Care for Direct-Care Workers.*

[iv] State of Iowa, Human Resources Enterprise, AFSCME Pay Plan SFY 2009.

[v] IHCA 2007 Nursing Home Cost Analysis, Appendix B 3-c of this report

[vi] AARP Insight on the Issues, *Valuing the Invaluable: The Economic Value of Family Caregiving*, November 2008

[vii] Iowa Direct Care Worker Task Force. 2006. *Iowa Direct Care Worker Task Force Report and Recommendations.* http://www.idph.state.ia.us/hpcdp/common/pdf/workforce/dcw_taskforce_1206.pdf

[viii] Iowa Direct Care Worker Task Force. 2006. *Iowa Direct Care Worker Task Force Report and Recommendations.* http://www.idph.state.ia.us/hpcdp/common/pdf/workforce/dcw_taskforce_1206.pdf

[ix] *The Health and Long-Term Care Workforce Review and Recommendations*, December 2007, Iowa Department of Public Health, http://www.idph.state.ia.us/hpcdp/common/pdf/health_care_access/hltcw_jan08.pdf

[x] Gibbs, R. and Parker, T. (2007) Rural Low-Wage Workers Face Multiple Economic Disadvantages. *Amber Waves.* USDA: Economic Research Service, Page 26 of 56 http://www.ers.usda.gov/AmberWaves/June07/Findings/Rural.htm

[xi] Dawson, S.L. 2007 *Recruitment and Retention of Paraprofessionals*. The Paraprofessional Healthcare Institute, http://www.paraprofessional.org/publications/Dawson_IOM_6-28-07.pdf

[xii] Iowa Better Jobs Better Care, *"Providing Health Care for Direct Care Workers – a Case Statement/Action Plan*, http://www.iowacaregivers.org

[xiii] Better Jobs Better Care Practice and Policy Report, *The Cost of Frontline Turnover in Long-Term Care*, October 2004, p. 9 and 21

[xiv] Iowa's Better Jobs Better Care Coalition, http://www.iowacaregivers.org/uploads/pdf/healthcareshortcasestatement.pdf

[xv] http://Phinational.org

[xvi] Iowa Health Care Association, 2007 LTC Revenue Mix Chart